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# Ascension

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 Affinity Medical Group  
 Calumet Medical Center  
 Mercy Medical Center  
 St. Elizabeth Hospital

## Impaired Practitioner or Allied Health Professional Policy

### Summary:

To recognize and actively manage provider impairment within Affinity Health System (AHS), so as to minimize any threat to patient safety. To provide early intervention in any practitioner or Allied Health Professional (AHP) impairment. To ensure patient safety and quality care by keeping professional behavior free from the effects of alcohol, drugs, or mental impairment.

### Background

The mission of Affinity Health System (AHS) calls us, to "live out the healing ministry of Christ". Our healing ministry is thus not just a job, but a way of life. It is impossible to live such a life without balance, and without appropriate self-nurturing. The practitioner and AHP Wellness Program exists specifically to promote such balance and nurturing. Our processes, policies and activities are all geared to promoting, improving and/or restoring balance and nurturing for our practitioners and allied health professionals (AHP). The activities of this program, thus, also support our Affinity values of service (by giving attention to the uniqueness of each of our practitioners and AHP's), integrity (by working to achieve the balance we believe in), Justice (by promoting and preserving the human dignity of our practitioners and AHP's), and stewardship (by wisely shepherding the valuable human resource of our practitioners and AHP's).

### DEFINITIONS

- I. Practitioner: This term means the following persons, possessing licenses to practice their profession: physicians, podiatrists, and dentists. The policy also applies to all practitioners granted temporary or emergency privileges.
- II. Allied Health Professional: This term means an individual who is either an independent AHP (doctors of psychology, nurse midwives, advanced practice nurse prescribers, and certified registered nurse anesthetists duly licensed to practice their profession) or a dependent AHP (duly qualified personnel employed by a physician or dentist, or by AHS to function within a campus as defined by Medical Staff policy).

- III. Impairment: Use or being under the influence of alcohol or other drugs, including prescription drugs and over-the-counter drugs, where there is any possibility that such use may reduce the practitioner's ability to safely perform his/her job with reasonable skill or may adversely affect patient safety and care or the safety of employees, visitors, other practitioners, or AHP's.
  - A. See APPENDIX A, "Monitoring a Practitioner for Chemical Dependence by the AHS Medical Staff" and "Observation Checklist" to assist in determining if a practitioner is impaired.
  - B. Impairment may also include mental/emotional illness, physical illness, senility, stress, sexual or behavioral disorders, or cognitive impairment. This type of impairment would NOT warrant use of the above monitoring forms.
- IV. Patient Contact or Treatment: For purposes of this policy, "patient contact or treatment" includes:
  - A. Personal contact of any kind by the practitioner on AHS property, and all AHS controlled locations, at any time.
  - B. Chart preparation or review, or the ordering of medications, diagnostic work, or treatments.
  - C. Review or interpretation of diagnostic test results, images, or other clinical findings.
- V. Designee: Any member of the relevant physician governance body: Combined Medical Executive Committee (MEC), and/or the Affinity Medical Group (AMG) and/or the Professional Governance Committee (PGC).

## **PROCEDURE**

### **PROCEDURE FOR ALL EMPLOYEES**

Any AHS employee or medical staff member who suspects, or has reason to believe, that a practitioner or AHP intends to engage in patient contact or treatment when having used or being under the influence of alcohol or other drugs shall follow the following procedure:

- I. If there is any possibility that such use may impair the practitioner's or AHP's ability to safely or effectively perform patient contact or treatment, the employee will immediately notify his/her Practice Manager or Supervisor. In the absence of the Practice Manager or Supervisor, the appropriate medical leader (medical director, vice president of medical affairs (VPMA), Staff President, Chief Medical Officer (CMO), etc.) will be notified.
- II. The employee should make every reasonable effort to prevent or delay patient contact or treatment until a manager or other representative arrives to assist.
- III. ALL EMPLOYEES ARE ASSURED OF PROTECTION AGAINST ANY RETALIATION OR REPERCUSSIONS STEMMING FROM GOOD FAITH EFFORTS TO ENFORCE THIS POLICY.

### **PROCEDURE FOR MANAGEMENT REPRESENTATIVES**

- I. The Manager, Supervisor or medical leader (medical director, VPMA, Staff President, CMO, etc.) will immediately go to the area in which the practitioner or AHP is located and make an assessment of the practitioner's/AHP's condition.

- II. If the management representative agrees that there is reason for concern, the practitioner should be prevented from performing patient contact or treatment.
- III. If the situation is not satisfactorily resolved the MEC or PGC Chair or designee should be contacted to assist.
- IV. Appropriate reporting of the concerns, indications of impairment, and actions taken are to be made at the earliest practical opportunity.
- V. As appropriate, the MEC or PGC chair will prepare a summary of the event for referral and evaluation to the Professional Activities Committee (PAC), and the Affinity Board of Directors.

#### SUGGESTIONS FOR MEC/PGC REPRESENTATIVE

- I. The practitioner or AHP may request a blood alcohol and urine drug screen, but the final decision as regards the capacity to function rests with the AHS Administrative representative and/or the MEC/PGC representative.
- II. It is the responsibility of the AHS Administrative representative or the MEC/PGC representative to arrange for the safe departure of the involved practitioner.

### APPENDIX A

#### MONITORING BY THE MEDICAL STAFF OF A PRACTITIONER OR ALLIED HEALTH PROFESSIONAL (AHP) JUDGED IMPAIRED BY CHEMICAL DEPENDENCE

##### OVERVIEW

- I. The purpose of monitoring is to assure the MEC/PGC that a practitioner or AHP with patient care responsibilities can perform his/her job safely.
- II. The MEC/PGC must be satisfied that the practitioner's or AHP's current health and mental health meet the Bylaws standards for appointment, reappointment or resumption of patient care.
- III. The MEC/PGC must acknowledge that ongoing, consistent monitoring is required for a specified period of time (a minimum of two years), and sufficient resources of physician time and attention must be allocated for it.

##### MONITORING PLAN AND MONITORING AGREEMENT

- I. A monitoring plan should be drawn up and it should serve as the basis of a monitoring agreement between the entity AHS Practitioner and Allied Health Professional Health and Wellness Intervener Committee and the practitioner or AHP. The following elements should be addressed as the plan is designed.
  - A. Treatment
    1. The MEC/PGC should satisfy itself that the practitioner or AHP receives appropriate treatment sufficient to assure that the problem is being addressed effectively.
    2. The MEC/PGC should satisfy itself that the practitioner's or AHP's current health and mental health are sufficient to allow him/her to practice safely.

3. An initial course of treatment appropriate to the situation should be instituted and completed.
4. The monitoring plan should incorporate the elements of an aftercare plan and recovery plan which have been recommended by those responsible for the initial treatment.
5. The resources of the AHS Practitioner and Allied Health Professional Health and Wellness Committee will be used as appropriate.

#### B. Release of Information

1. The AHS Practitioner and Allied Health Professional Health and Wellness Intervener Committee should require that the practitioner or AHP authorize the therapist(s) to communicate information to that Committee using that Committee's usual processes. Information should come from those responsible for primary care (initial treatment) as well as aftercare and/or ongoing care.

#### C. Recovery Plan

1. The practitioner or AHP should have a specific, ongoing recovery plan sufficient to the situation and to the practitioner's or AHP's status in recovery. The monitoring plan should be designed to accumulate the information which will, over time, document the practitioner's or AHP's participation in this recovery program.
2. All written information regarding impairment will be through the entity AHS Practitioner and Allied Health Professional Health and Wellness Intervener Committee.

#### D. Information to be Gathered and Reviewed

1. Information about the health status of the practitioner or AHP in recovery and about his/her performance should be gathered and reviewed. The process of gathering and evaluating such information is called monitoring.
2. Information should come from several sources appropriate to the practitioner's or AHP's situation, such as from the hospital work place, body fluid test results, an aftercare coordinator, ongoing therapist, family, office colleagues.
3. The MEC/PGC should designate those who are in a position to gather and submit to the coordinator of monitoring the different kinds of information appropriate to the case. Any monitors so appointed shall be members of a entity AHS Practitioner and Allied Health Professional Health and Wellness Intervener Committee, a subcommittee of the AHS PAC, and thus, have peer review protection.

#### E. Regular Contact with a Knowledgeable Observer

1. There should be regular, face-to-face contact between the practitioner or AHP and a monitor knowledgeable about chemical dependence and about what to look for in a practitioner or AHP with the condition being monitored. Time and place of the contact should vary. Frequency and length of contact should be determined for each case. For some, daily or even more than once-a-day contact may be indicated, especially in the first days/weeks of the monitoring process. Most usually, three times a week would be considered a minimum for the initial period. Frequency would vary with the particular practitioner's or AHP's status in recovery.

Length of contact must be sufficient to make an observation of the practitioner's or AHP's behavior. The record should include periodic notes based on this observation.

2. Monitors should be able to create a relationship of mutual trust, support, helpfulness and respect. Monitors, however, should maintain objectivity and diligence throughout the monitoring process.

#### F. Coordinator of Monitoring

1. All who serve as sources of information should report to one coordinator of monitoring for the case, and that person should be a member of the AHS Practitioner and Allied Health Professional Health and Wellness Intervener or Advisory Committee. The function of the coordinator is to assemble all the information and to review, interpret, evaluate and respond to the comprehensive picture.

#### G. Body Fluid Testing

1. Body fluid testing is desirable as one element of a monitoring plan. Body fluids (most commonly urine) should be collected on a random schedule and under direct observation. NOTE: Body fluid alone does not comprise a sufficient monitoring plan and is not the highest priority element of the plan. Greater weight is given to regular observation of behavior by a knowledgeable monitor.
2. The monitoring agreement should specify what role body fluid testing will have in the overall monitoring plan. Where body fluid testing is required, the test done must be able to detect the drug(s) which the physician or AHP might use. The agreement should describe how positive results will be interpreted and what will be the response of the MEC/PGC to positive results. The monitoring agreement should specify the costs of testing and who pays the costs. The results should be sent to the coordinator of monitoring.

#### H. Regular Conferences

1. There should be a mechanism for face-to-face conferences, at the request of any of these parties, between the monitors, the practitioner or AHP monitored, and the coordinator of monitoring. The AHS Practitioner and Allied Health Professional Health and Wellness Intervener or Advisory Committees may also be involved.

#### I. Re-evaluation of the Recovery Plan and the Monitoring Plan

1. There should be regular re-evaluation at some interval, perhaps every six months, of the monitoring plan to assure that it is sufficient to the need but does not require elements no longer necessary to the situation. Changes in the plan should be made so that it fits the current situation of the practitioner or AHP and his/her status in recovery.
2. It may or may not be appropriate to have this evaluation made by an acknowledged expert outside of the Medical Staff who will provide a written report. The monitoring agreement should specify the costs of this evaluation and who pays the cost.

#### J. Record Keeping

1. For each case where there is monitoring, there must be a record. The record

should include a copy of the signed monitoring statement between the practitioner or AHP and the MEC/PGC . The Board must have adequate information to assess the practitioner's or AHP's status in recovery and compliance with the elements in the agreement.

2. This information must be accumulated in the record and must be kept in strict confidence, preferably in a locked file or other secure storage which may be accessed only by the MEC/PGC Chair and the AHS Practitioner and Allied Health Professional Health and Wellness Intervener or Advisory Committee members. This information should be retained indefinitely, preferably as long as the practitioner or AHP practices in AHS, plus five years. Disclosure of this information, except to the MEC/PGC or AHS Practitioner and Allied Health Professional Provider Health and Wellness Committee, should be made only at the written request of the individual involved or with the advice of legal counsel.

#### K. Response to "Slips"

1. The monitoring plan should take into consideration the fact that a relapse or resumption of use of alcohol or drugs (or "slip") is not uncommon phenomenon for those recovering from chemical dependence, especially in the early phases of recovery. Statistics show that slips occur in a significant percent of cases usually within the first year of sobriety.
2. The response to a slip should be the same as a response to the initial diagnosis; that is, the slip should be assessed by a knowledgeable, experienced evaluator and the response should be tailored to the situation. A slip alone should not be considered cause for termination of privileges or loss of employment or position. The customary response to a slip is to intensify the treatment plan, of which monitoring is a part, for a period of time appropriate to the case. It may or may not be appropriate to require that the practitioner or AHP take a leave from patient care for a period of time appropriate to the situation. Consideration should be given to the practitioner's or AHP's health and to patient safety in reaching a decision about whether a leave is appropriate.

## PURPOSE OF MONITORING

- I. The purpose of monitoring described here is to assure the MEC/PGC that the practitioner or AHP is in recovery, continues in recovery and is participating in an appropriate recovery program.
- II. Monitoring is a service to the practitioner or AHP as well as to the MEC/PGC . For the practitioner or AHP, a comprehensive monitoring program establishes a history of performance, with documentation, which can be invaluable in vouching for a practitioner's or AHP's current status in recovery. For the MEC/PGC, a record is established over time, showing that they are acting in a knowledgeable, timely, thorough and responsible way to assure that the practitioner or AHP continues to deliver safe care.

## **MONITORING FOR CONDITIONS OTHER THAN CHEMICAL DEPENDENCE**

- I. When monitoring for situation or condition other than chemical dependence is required, all principles of monitoring described herein should be adapted and applied. Such a situation would not require drug testing, for example.

## **PROCTORING**

- I. The MEC/PGC must also satisfy itself that the practitioner's or AHP's clinical skills are intact. To that end, the monitoring plan should contain provisions for proctoring, appropriate to each case.
- II. There should be concurrent peer review and regular record review for all monitored practitioners or AHP's, for a period of time to be determined in each case. For those with surgical privileges, or those who perform other procedures in AHS facilities, there should be a proctor for a period of time to be determined in each case.

## **WHEN THE PRACTITIONER OR AHP HAS PRIVILEGES/DUTIES AT MORE THAN ONE LOCATION**

- I. The monitoring agreement should provide for notifying the appropriate medical staff committee(s) of other institution(s) where the practitioner or AHP has privileges/duties. In an optimal situation, monitoring activities will be integrated in a way which meets the responsibilities of each medical staff without unnecessary duplication. At a minimum, each medical staff should have a monitoring agreement (or each medical staff should be a party to one monitoring agreement) and there should be regular contact with a knowledgeable observer at each hospital whose reports are submitted to one coordinator of monitoring.

## **PROTECTION OF THE PRACTITIONER'S OR AHP'S IDENTITY**

- I. It is possible to carry out every element of monitoring described here and still protect the identity of the practitioner or AHP. The practitioner's or AHP's identity and information about the situation needs to be known only to the signers of a monitoring agreement, the monitors and the AHS Practitioner and Allied Health Professional Health and Wellness Committee and/or the MEC/PGC as they might be responsible for the monitoring. Disclosure of this information may be required if it becomes relevant in a staff privilege dispute.

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### **Attachments:**

[Consent for release of information pertaining to initial evaluation](#)  
[Consent for release of information pertaining to rehabilitation/treatment program](#)  
[Monitoring Agreement](#)  
[Observation Checklist](#)  
[Report to physician leadership committee regarding provider health status monitoring](#)